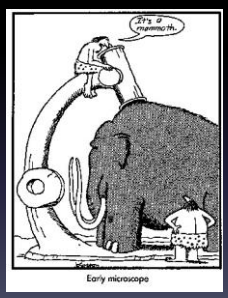
Workers Compensation and the Shoulder

Michael T. Daines, MD

Medical Education

- Repetition
- 50% of what you learn is wrong



Obligatory about me slide

- Boise Native
- Undergraduate degree in Biology at the University of Utah
- Columbia Medical School
- University of Iowa Hospitals and Clinics
- Oxford University, Shoulder fellowship

Post Education

- 2009-2013 Hospital employed orthopedics in Colorado
- November 2013 moved into private practice with West Idaho Orthopedics
- I have a general practice but specialize in shoulder
  - 50% shoulder, growing

The Workers Comp Shoulder

- Impossibly broad
- Focus on common injury patterns
- Structured around common questions I have heard from adjustors, nurse managers and patients
- Ample time at the end for questions

The shoulder

- Economics!
  - 5 million shoulder visits for rotator cuff pathology in a six year period of observation by the AAOS
  - Estimates of 5-60 percent of adults over 50 have a rotator cuff tear!
- Shoulder medicine will be a huge part of any medical practice in the modern era
- Getting it right is difficult!

Shoulder medicine

- Youngest subspecialty
- Active growth
- Techniques have improved dramatically
- Fellowship trained specialists

Challenges

- People are living longer
- Active later in life
- Aging workforce
- Higher injury rate?

Challenges of an aging workforce

- Injury patterns
- Chronic conditions
- Apportionment?
- Causation?
- Obligations

The shoulder patient

Young patients

- Accident
- Dislocations
- Fractures
- Mechanical trauma

Less young patients

- Insidious onset of pain
- Minor trauma, fail to improve
- Rotator cuff
- Arthritis

Middle Aged Man

- Insidious onset of pain
- Sometimes associated with minor accident
- Seems worse at work
- Night pain common

Exam

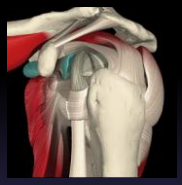
- Relatively benign
- Pain overhead
- No weakness
- Impingement signs

What do we call it?

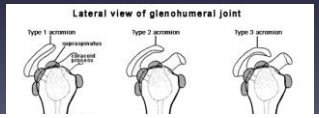
- Impingement
- Bursitis
- Tendinitis

Impingement

- Symptoms worse with repetitive overhead work



- Associated with a 'hooked' acromion



Middle aged man

- What now?
- Need a systematic approach
- History needs to be complete and accurate
  - Prior history?
- Good physical exam

Just Pain

- NSAIDS
  - Use like a medicine
  - 6 weeks
  - How do you define success?

Just pain

- If pain is improved with NSAIDs
  - Home exercise program
  - PT
- If not Inject
- Wait six weeks

Just pain

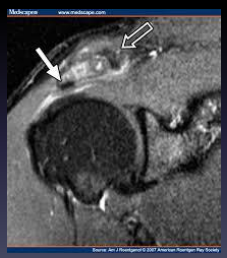
- Improvement?
  - PT
  - Home exercise
- If not
  - MRI
  - Specialist Referral

When To Refer?

- MRI findings
- Failure to improve as expected
- Worse
- Losing the debate

MRI findings

- Impingement
- Bursitis
- Tendinosis
- Rotator cuff tears
  - Partial
  - Complete
  - Fake!

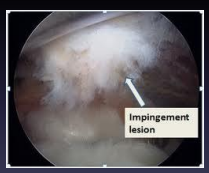


How Long Do You Wait?

- Medicare guidelines state six months
- Reality is if you don't see improvement with NSAIDs and injections, time will not help
- Cut to the chase!

Decompression

- Often see evidence of mechanical abrasion



Expected Outcome Decompression

- Light duty within 2 days
- Gradual increase in activity
- Full duty within six weeks
- Therapy starts when pain is under control
- MMI at 3 months
- Usually no need for an impairment rating
- Time to recovery depends on what else you find at arthroscopy

59 year old Laborer

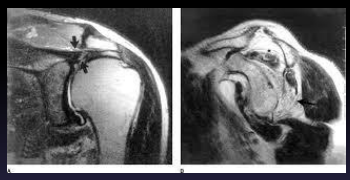
- Works on a truck
- Previous Shoulder injury
  - Closed
  - Documented return to normal function
- Documented at normal work function

Injury

- Dreaded pop in his shoulder
- Unable to elevate his arm
- Pain 10/10
- Unable to return to work

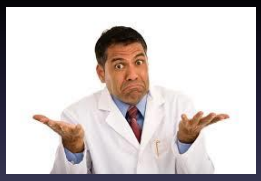
Exam

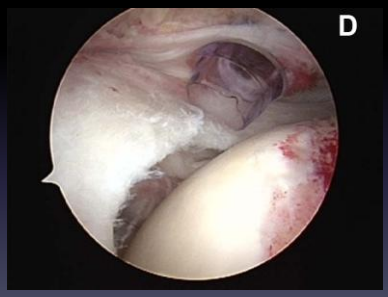
- Profound weakness
- Atrophy
- Range normal
- Pain
- crepitance



How do you resolve this one?

- Acute?
- Chronic
- Mix?
- Apportionment?

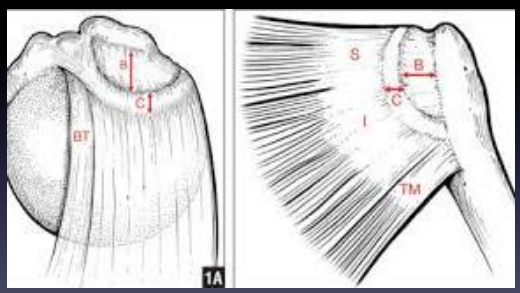


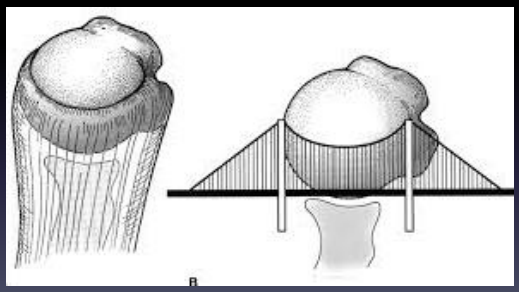


Outcome

- Failed repair
- Poor functional outcome
- Permanent restrictions

Rotator cable





Sticky Questions

- Apportionment?
- Permanent restrictions?
- 70/30
- Permanent restrictions
- Impairment rating

63 year old data entry clerk

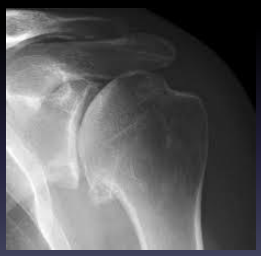
- Insidious onset of shoulder pain
- Mild mechanical symptoms
- Pain worse with activity
- Relieved by rest

Exam

- Limited External Rotation
- Crepitance
- Cogwheel rigidity
- Neuro intact.
- Good cuff strength

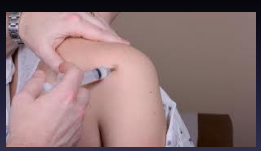
X-ray

- Osteoarthritis
- Clearly not related to work conditions



Glenohumeral Arthritis

- Aggravation
- Treat to resolution of current episode
- Apportion to the pre-existing condition



Extenuating circumstances?

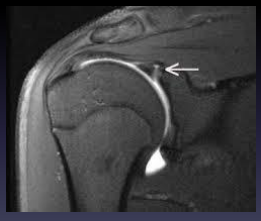
- Heavy manual labor
- Work related fracture

45 year old male

- Minor work injury
- Mild pain and mechanical symptoms
- Pain relieved by rest, injection

SLAP

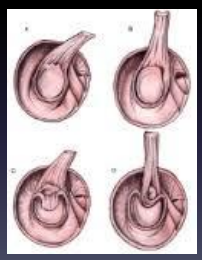
- Now what?
- Does it need to be fixed?
- Related to the injury



What is a SLAP?

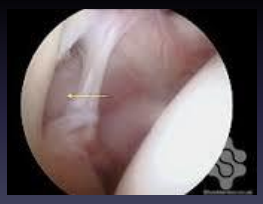
- Destabilization of the biceps anchor
- Most common in athletes
- Requires a traction injury to occur
- RARE as a work comp diagnosis
- MRI sensitivity

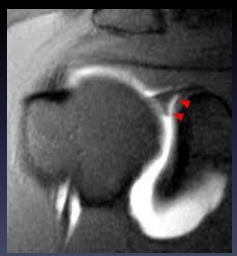
Superior Labral Lesions



- 4 types
- Generally type two requires surgery
- There are many variants of normal anatomy that appear SLAP like on MRI
- Don't be fooled!
- Accurate diagnosis is the key

Sublabral Foramen





Presentation

- Vague anterior shoulder pain
- Mechanical symptoms
- Must give an appropriate history to consider SLAP
- MRI findings should match
- Physical exam is difficult but critical to detect a true symptomatic SLAP

Treatment

- Type 2 does well with surgical repair
- All others should be debrided
- Special caution in patient over 40
  - High incidence of post operative stiffness
  - Failed outcomes

Expected Outcome

- Return to sedentary work within 2 days
- Return to use of the arm within 4-6 weeks
- Full duty within 12 weeks
- MMI at 4 months

Pearls

- Create a system and follow it
- Early referral if no response to appropriate treatment
- First history is critical to outcome, apportionment